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HEALTH OBJECTIVES FOR THE YEAR 2000: THE NORTH CAROLINA CHALLENGE

by

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BACKGROUND

The beginning of the 21st century beckons with both challenge and opportunity for the improved health of all Americans. The report, *Healthy People 2000: National Health Promotion and Disease Prevention Objectives*,[1] sets out a national agenda for the 10 years leading up to 2000. It follows a similar agenda published for the 1980s.[2]

Involving professionals, other citizens, private organizations and public agencies from every part of the country, *Healthy People 2000* offers a vision for the new century. This vision is characterized by significant reductions in preventable death and disability, enhanced quality of life, and greatly reduced disparities in the health status of populations within our society. Those goals are addressed through the declaration of several hundred health objectives covering 21 areas of pregnancy, death, disease, preventive interventions, and health-related behaviors.

Meanwhile, keenly aware of North Carolina's unfavorable ranking on many of the national health status indicators, Governor James G. Martin established in August 1991 the Governor's Task Force on Health Objectives for the Year 2000. The deliberations of this 25-member body resulted in the November 1992 publication of objectives addressing 11 broad areas of concern: injury; infant death; immunization; dental decay; physical fitness; nutrition; sexually transmitted diseases; abuse of tobacco, alcohol, and other drugs; mental health; chronic diseases, and environmental pollution.[3] The report of the Task Force identifies special target populations and emphasizes community-based intervention strategies. To date, leaders in 43 of the state's 100 counties have plans to develop responsive health improvement plans for their communities; and 13 counties already have active *Healthy Carolinians 2000* task forces.

In September 1992, the North Carolina Department of Environment, Health, and Natural Resources was successful in winning a grant award from the Centers for Disease Control and Prevention (CDC) to increase state and local capacity to evaluate progress toward Healthy People 2000 objectives and to use this information for policy making and program management. Delton Atkinson, director of the State Center for Health and Environmental Statistics, oversees this 5-year grant. The activities in this project are directly related to objectives in *Healthy People 2000*. Objective 22.5 emphasizes the need for measurement of progress: "Implement in all states periodic analysis and publication of data needed to measure progress toward objectives for at least 10 of the priority areas of the national health objectives." Objective 22.5a emphasizes "periodic analysis and publication of state progress toward the national objectives for each racial or ethnic group that makes up at least 10 percent of the state population." Objective 22.6 is geared toward systems for the transfer of health information related to the national health objectives among federal, state, and local agencies.

Meanwhile, one-year funding from the Public Health Foundation has enabled the State Center to begin minority studies[4-7] and to establish a minority health surveillance system. Against that background, the CDC grant now allows for ongoing evaluation of the state's progress toward the Year 2000 national health objectives, in total and for minorities, and establishment of a related electronic health information system covering the entire population as well as the Black and American Indian groups.

As a first step in achieving the goals of the Year 2000 grant from CDC, the present report purports to assess North Carolina's status with respect to selected national health objectives, specifically, a) those included in a consensus set of indicators selected by CDC and the nation's six major public health organizations,[8] and b) objectives specific for Blacks and American Indians for which data are available. Objectives for Hispanics and for Asians and Pacific Islanders are not examined due to data problems known to exist for Hispanics[7] and the small size of the Asian/Pacific Islander population—52,166 or 0.8 percent of the state's population in 1990. By comparison, Blacks numbered 1.46 million (22%) in 1990 while the much smaller American Indian population numbered 79,825 (1.2%); these two minority groups are the focus of studies funded in part by the Public Health Foundation.[4-6]

CONSENSUS SET OF HEALTH INDICATORS

Objective 22.1 of *Healthy People 2000* requires the development of a set of health status indicators appropriate for federal, state, and local health agencies. A committee, assembled by CDC and representing the nation's six major public health organizations, has developed a consensus set of 20 such indicators, priority being given to those measures for which data are readily available and the measures are commonly used in public health.[8]

For 15 of the 20 consensus indicators, Table 1 provides the Year 2000 objective and the North Carolina statistic for each year 1990-1992. As described in table note 1, U.S. objectives have not been established for three indicators, and North Carolina data are not available for two others. The reader should also note the indicators typed in italics; these or similar indicators are among the *Healthy Carolinians 2000* set developed by a state task force[3] and currently being addressed through community-based health improvement programs across the state.

As shown in Table 1, the North Carolina lung cancer death rate for each year 1990-1992 was near or below the Year 2000 objective. Unfortunately, this is the only one of the 15 consensus indicators on which the state ranks relatively well.

By and large, North Carolina indicators for the early 1990s are far from the Year 2000 objectives for the U.S. That raises the point: are the U.S. single-point objectives entirely appropriate for states whose baselines are so poor relative to those for the nation? Probably not, but the fact remains that each state should realize progress toward a specific objective. For the following

indicators, the North Carolina statistic showed no improvement or a deterioration between 1990 and 1992:

Indicator	Percent Increase 1990-1992	Ratio: NC 1992 to Year 2000 Target
• Female breast cancer death rate	1.4	1.07
• Homicide rate	3.5	1.64
• Percent low birthweight	5.0	1.68
• Primary/secondary syphilis rate	38.3	3.65

For the first three of these indicators, an increase occurred in 1991 only, so an upward trend has not been established. Still, the desired downward trend also cannot be claimed.

On a more positive note, Table 1 reveals improvement since 1990 in most of the Year 2000 consensus indicators. Three of these having minority subobjectives are charted in Figures 1-3.

MINORITY OBJECTIVES

As described in recent reports,[4-7] minority health has the attention of North Carolina's health community. This is due in part to a 1987 study[9] that highlighted the disproportionate illness and death being experienced by minorities and how this disparity had not been appreciably altered in the recent past. That study led to creation of a Minority Health Task Force in the Department of Environment, Health, and Natural Resources, which in turn contributed to the formation of the Minority Health Center, a private agency focused on advocacy, research, project demonstration, and technical assistance.

More recently, the Office of Minority Health and an advisory body, the Minority Health Advisory Council, have been created in the department. The State Center has worked closely with these groups as well as the Commission for Indian Affairs and others to provide race-specific data and to determine the content of our recent minority studies. Health objectives for minorities (Blacks and American Indians) will be a focus of the CDC grant activities.

Some of the consensus indicators of Table 1 have corresponding subobjectives for minorities. In addition, there are several other Year 2000 minority health objectives which have obvious public health significance and for which we have annual measures. These minority indicators are shown in Table 2 for Blacks and Table 3 for American Indians. Complete lists of the Year 2000 objectives targeting Blacks and American Indians are provided in Appendices 2 and 3 respectively.

Blacks

In most cases, the North Carolina baseline (1990) rate for Blacks is far from the national objective (Table 2). Moreover, the following state rates for Blacks show no improvement or a deterioration between 1990 and 1992:

Indicator	Percent Increase 1990-1992	Ratio: NC 1992 to Year 2000 Target
· Drowning, males	11.5	1.61
· Residential fire, males	43.9	1.91
· Homicide, males 15-34	14.9	1.29
· Homicide, females 15-34	38.5	1.51
· Percent low birthweight	3.1	1.48
· Percent very low birthweight	3.3	1.55
· Postneonatal death rate	15.6	1.30
· Fetal death rate	4.3	1.96
· Primary/secondary syphilis rate	39.5	2.34

Figures 1-5 depict 1990-1992 rates and Year 2000 goals for five objectives that target Blacks. For both male and female Blacks aged 15-34, the homicide rate was higher in 1992 than in 1990, as shown above and in Figure 5.

FIGURE 1
Infant Death Rates by Race
North Carolina 1990-92 and Year 2000 Objectives

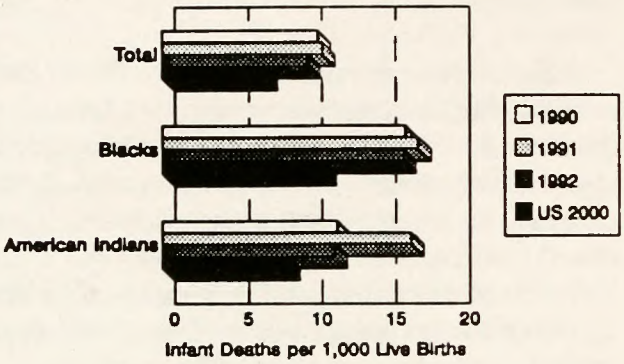


FIGURE 2
Percent Prenatal Care in First Trimester by Race
North Carolina 1990-92 and Year 2000 Objective

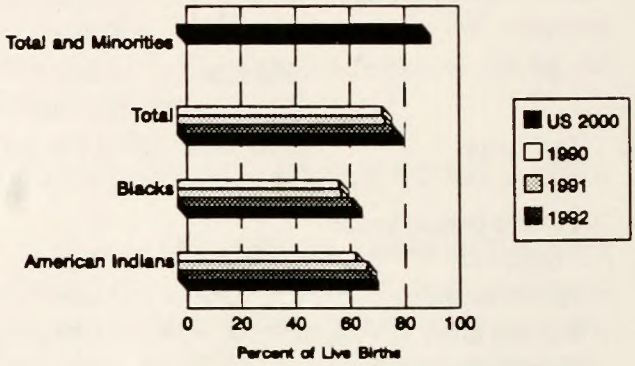


FIGURE 3
Tuberculosis Case Rates by Race
North Carolina 1990-92 and Year 2000 Objectives

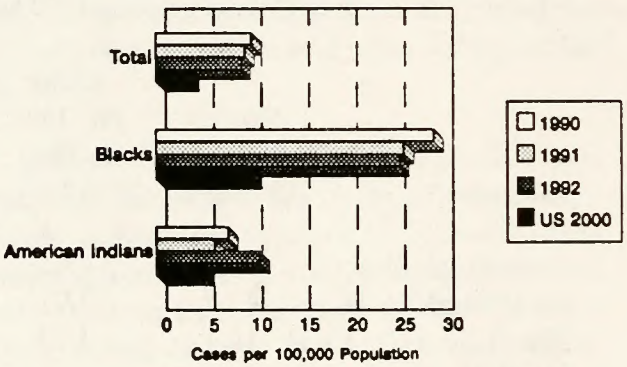


FIGURE 4
Diabetes-Related Death Rates by Race
North Carolina 1990-92 and Year 2000 Objectives

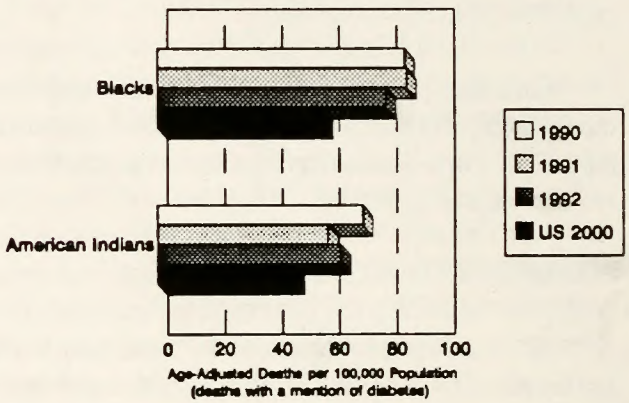
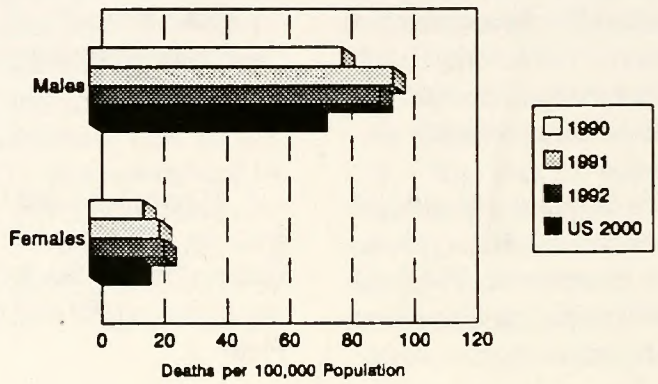


FIGURE 5
Homicide Rates for Blacks 15-34 by Sex
North Carolina 1990-92 and Year 2000 Objectives



Using *Healthy People 2000* as a guide, Schneider[10] has identified "the major public health goals and objectives that Black public health and political leaders agreed were of highest priority for Black Americans: those that are both important and most likely to be successfully addressed." In a nationwide survey, responding Black health leaders ranked reducing alcohol and other drug abuse of primary importance, followed by preventing and controlling the human immunodeficiency virus (HIV) and the acquired immunodeficiency syndrome (AIDS) and preventing, detecting, and controlling hypertension, heart disease and stroke. Black mayors listed preventing and controlling HIV/AIDS as of primary importance, followed by preventing and controlling sexually transmitted diseases and reducing alcohol and other drug abuse. Black legislators were split between reducing alcohol and other drug abuse, preventing and controlling HIV/AIDS, and improving maternal and infant health as of primary importance.

The prevention, detection and control of cancer, diabetes, and other disabling conditions were also seen as very important goals. Two objectives—reducing alcohol/drug abuse and reducing violence/abuse—were considered more resistant to change than others.

American Indians

As shown in Table 3, the state's American Indian death rates for unintentional injuries, motor vehicle unintentional injuries, and cirrhosis of the liver were each higher in 1992 than in 1990. However, due to the small numbers involved in the age-adjustment procedure, the death rates for Indians—the cirrhosis rate in particular—are prone to random fluctuation. Small numbers may also contribute to the rise observed in the tuberculosis case rate for Indians.

Figures 1-4 depict 1990-1992 rates and Year 2000 goals for four objectives that target American Indians as well as Blacks.

DISCUSSION

North Carolina is fortunate to have Community Diagnosis, an established system for evaluating needs at the local level.[11] Every two years, statisticians from the State Center prepare 100 county-specific health data books with an accompanying guide. The statisticians then train county health department personnel to analyze their data and local situations to identify their county's most pressing health problems.

For its 1993-94 cycle, which began in September with basic and advanced workshops held at three locations across the state, the State Center has given special attention to the Year 2000 national objectives as well as the objectives of *Healthy Carolinians 2000*. This is accomplished through a new section in the county data book (titled "Health Objectives for the Year 2000")[12] where data are provided for those objectives for which adequate county-level data are available. Altogether, the latest available 3- or 5-year measures are presented for 40 objectives; the county assesses its current status relative to each Year 2000 goal through the completion of worksheets provided in the accompanying guide.[13]

Meanwhile, the State Center is pursuing several other initiatives funded by the Healthy People 2000 cooperative agreement with CDC. This includes investigating alternative means of tracking objectives and transferring data to local health departments. The long-term goal is to build a coordinated statewide network of state/local health departments and their affiliates which is focused on the use of high-quality assessment information for policy development and program management.

Through these efforts, combined with those of the community-based *Healthy Carolinians 2000* project, it is hoped that North Carolina can achieve many of the Year 2000 national health objectives, or at least be headed in the right direction by century's end.

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TABLE 1

Healthy People 2000 Consensus Set of Indicators

Indicator	U.S. Year 2000 Objective	North Carolina 1990	1991	1992
Indicators of Health Status Outcome				
• *Infant Death Rate*[1]	7.0	10.6	10.9	9.9
Blacks[1,2]	11.0	16.5	17.4	16.4
American Indians[1,2]	8.5	11.9	16.9	11.7
Death Rates[3]				
• *Motor Vehicle*	16.8	21.2	20.1	18.6
• *Suicide*	10.5	12.9	11.4	11.4
• *Lung Cancer*	42.0	42.6	40.5	41.9
• Female Breast Cancer	20.6	21.8	22.7	22.1
• *Coronary Heart Disease*	100.0	129.0	125.4	121.3
• Homicide	7.2	11.4	13.2	11.8
Reported Incidence				
• AIDS	No more than 1993 incidence	533 cases	596 cases	658 cases
• Measles	Zero	39 cases	44 cases	24 cases
• Tuberculosis[4]	3.5	10.0	9.3	8.9
• *Primary/Secondary Syphilis*[4]	10.0	26.4	29.8	36.5
Indicators of Risk Factors				
• *Percent Low Birthweight*	5.0	8.0	8.4	8.4
• Percent Prenatal Care in 1st Trimester	90.0	75.4	76.3	79.2

Italic type indicates that Healthy Carolinians 2000 includes an objective for the same or a similar indicator.

[1]Infant deaths per 1,000 live births.

[2]Live births use the definition of a newborn's race as that of its mother. Prior to 1990 for N.C. and 1989 for the U.S., the darker of the mother's and father's race (if different) was ascribed to the newborn at birth.

[3]Deaths per 100,000 population, using 1940 U.S. population and 10-year age groups as the standard for direct age adjustment. Age-specific denominators for 1991 and 1992 are straight-line extrapolations of the 1980 and 1990 censuses.

[4]Cases per 100,000 population.

Notes: 1) U.S. objectives have not been established for three consensus indicators: age-adjusted total death rate, percent births to adolescents (10-17), and percent children <15 years of age living in families at or below the poverty level. For "deaths from work-related injuries per 100,000 full-time workers," a North Carolina denominator is not available. For "proportion of persons living in counties exceeding U.S. Environmental Protection Agency standards for air quality," North Carolina data are not available.

2) Cause-of-death codes for mortality objectives are found in Appendix 1.

TABLE 2

Healthy People 2000 Objectives Targeting Blacks

Indicator	U.S. Year 2000 Objective	North Carolina 1990	1991	1992
• Coronary heart disease death rate[1]	115.0	158.9	156.4	151.9
• Stroke death rate[1]	27.0	61.1	57.4	57.5
• Diabetes-related death rate[1]	58.0	86.3	86.9	79.7
• Cirrhosis death rate for males[1]	12.0	24.1	18.7	19.0
• Unintentional injuries death rate for males[1]	51.9	80.5	75.2	77.1
Falls and related injury, males 30-69[2]	5.6	8.2	8.0	6.0
Drowning, males[1]	3.6	5.2	7.7	5.8
Residential fire, males[1]	4.3	5.7	5.5	8.2
females[1]	2.6	3.0	3.7	1.5
• *Homicide, males 15-34*[2]	72.4	81.1	97.3	93.2
females 15-34[2]	16.0	17.4	22.4	24.1
• Maternal death rate (per 100,000 live births)[3]	5.0	45.5	6.6	26.4
• *Percent low birthweight (under 2500 grams)*[3]	9.0	12.9	13.1	13.3
• Percent very low birthweight (under 1500 grams)[3]	2.0	3.0	3.0	3.1
• Fetal death rate (20+ weeks, per 1,000 deliveries)[3]	7.5	14.1	12.9	14.7
• Neonatal death rate (per 1,000 live births)[3]	7.0	11.9	12.0	11.2
• Postneonatal death rate (per 1,000 live births)[3]	4.0	4.5	5.4	5.2
• *Infant death rate (per 1,000 live births)*[3]	11.0	16.5	17.4	16.4
• Percent prenatal care in 1st trimester[3]	90.0	59.4	60.2	64.5
• Pregnancy rate for girls 15-19 (per 1,000 population)[3]	120.0	155.3	156.1	150.4
• AIDS (cases)	No more than 1993 incidence	332 cases	366 cases	409 cases
• *Primary/secondary syphilis rate*[4]	65.0	108.8	124.7	151.8
• Gonorrhea rate[4]	1300.0	1865.6	2214.9	1580.7
• Tuberculosis rate[4]	10.0	29.0	25.9	25.4

Italic type indicates that Healthy Carolinians 2000 includes the same or a similar indicator for nonwhites.

[1]Deaths per 100,000 population, using 1940 U.S. population and 10-year age groups as the standard for direct age adjustment. Age-specific denominators for 1991 and 1992 are straight-line extrapolations of the 1980 and 1990 censuses.
[2]Deaths per 100,000 population.
[3]Live births use the definition of a newborn's race as that of its mother. Prior to 1990 for N.C. and 1989 for the U.S., the darker of the mother's and father's race (if different) was ascribed to the newborn at birth.
[4]Cases per 100,000 population.
Note: Cause-of-death codes for mortality objectives are found in Appendix 1.

TABLE 3

Healthy People 2000 Objectives Targeting American Indians

Indicator	U.S. Year 2000 Objective	North Carolina 1990	1991	1992
• Unintentional injuries death rate[1]	66.1	52.4	55.3	59.3
• Motor vehicle death rate[1]	39.2	36.2	38.3	37.6
• Suicide[1]	12.8	11.2	10.2	9.5
• Homicide[1]	11.3	23.0	19.8	18.8
• Cirrhosis death rate[1]	13.0	4.4	8.2	17.5
• Diabetes-related death rate[1]	48.0	71.6	59.4	64.0
• Infant death rate (per 1,000 live births)[2]	8.5	11.9	16.9	11.7
• Postneonatal death rate (per 1,000 live births)[2]	4.0	3.3	6.2	2.0
• Percent prenatal care in 1st trimester[2]	90.0	65.6	69.6	70.3
• Tuberculosis rate (per 100,000 population)	5.0	7.5	6.1	10.8

[1]Deaths per 100,000 population, using 1940 U.S. population and 10-year age groups as the standard for direct age adjustment. Age-specific denominators for 1991 and 1992 are straight-line extrapolations of the 1980 and 1990 censuses.

[2]Live births use the definition of a newborn's race as that of its mother. Prior to 1990 for N.C. and 1989 for the U.S., the darker of the mother's and father's race (if different) was ascribed to the newborn at birth.

Note: Cause-of-death codes for mortality objectives are found in Appendix 1.

APPENDIX 1

IDENTIFYING CODES FOR HEALTHY PEOPLE 2000 MORTALITY OBJECTIVES

(in alphabetical order)

Cause of Death	Codes from the International Classification of Diseases—9th Revision
Breast cancer in women	174
Cirrhosis	571
Coronary heart disease	410-414, 402, 429.2
Diabetes-related deaths	250
Drowning	E830, E832, E910
Falls and related injury	E880-E888
Homicide	E960-E969
Lung Cancer	162.2-162.9
Maternal mortality	630-676
Motor vehicle crashes	E810-E825
Residential fires	E890-E899
Stroke	430-438
Suicide	E950-E959
Unintentional injuries	E800-E949

APPENDIX 2

Healthy People 2000
Objectives Targeting Blacks

2.3b* Reduce overweight to a prevalence of no more than 30 percent among black women aged 20 and older. (Baseline: 44 percent for black women aged 20 through 74 in 1976-80)

Note: For people aged 20 and older, overweight is defined as body mass index (BMI) equal to or greater than 27.8 for men and 27.3 for women. For adolescents, overweight is defined as BMI equal to or greater than 23.0 for males aged 12 through 14, 24.3 for males aged 15 through 17, 25.8 for males aged 18 through 19, 23.4 for females aged 12 through 14, 24.8 for females aged 15 through 17, and 25.7 for females aged 18 through 19. The values for adolescents are the age- and gender-specific 85th percentile values of the 1976-80 National Health and Nutrition Examination Survey (NHANES II), corrected for sample variation. BMI is calculated by dividing weight in kilograms by the square of height in meters. The cut points used to define overweight approximate the 120 percent of desirable body weight definition used in the 1990 objectives.

2.4a Reduce growth retardation among low-income black children younger than age 1 to less than 10 percent. (Baseline: 15 percent in 1988)

Note: Growth retardation is defined as height-for-age below the fifth percentile of children in the National Center for Health Statistics' reference population.

2.10e Reduce the prevalence of anemia to less than 20 percent among black, low-income pregnant women. (Baseline: 41 percent of those aged 15 through 44 in their third trimester in 1988)

Note: Iron deficiency is defined as having abnormal results for 2 or more of the following tests: mean corpuscular volume, erythrocyte protaporphyrin, and transferrin saturation. Anemia is used as an index of iron deficiency. Anemia among Alaska Native children was defined as hemoglobin <11 gm/dL or hematocrit <34 percent. For pregnant women in the third trimester, anemia was defined according to CDC criteria. The above prevalences of iron deficiency and anemia may be due to inadequate dietary iron intakes or to inflammatory conditions and infections. For anemia, genetics may also be a factor.

3.4d* Reduce cigarette smoking to a prevalence of no more than 18 percent among blacks aged 20 and older. (Baseline: 34 percent in 1987)

Note: A cigarette smoker is a person who has smoked at least 100 cigarettes and currently smokes cigarettes.

4.2a Reduce cirrhosis deaths among black men to no more than 12 per 100,000 black men. (Age-adjusted baseline: 22 per 100,000 in 1987)

5.1a Reduce pregnancies among black adolescent girls aged 15 through 19 to no more than 120 per 1,000 black adolescents. (Baseline: 186 per 1,000 for non-white adolescents in 1985)

Note: For black and Hispanic adolescent girls, baseline data are unavailable for those aged 15 through 17. The targets for these two populations are based on data for women aged 15 through 19. If more complete data become available, a 35-percent reduction from baseline figures should be used as the target.

5.2a Reduce to no more than 40 percent the proportion of all pregnancies among black women that are unintended. (Baseline: 78 percent of pregnancies in the previous 5 years were unintended, either unwanted or earlier than desired, in 1988)

5.3a Reduce the prevalence of infertility among black couples to no more than 9 percent. (Baseline: 12.1 percent of married couples with wives aged 15 through 44 in 1988)

Note: Infertility is the failure of couples to conceive after 12 months of intercourse without contraception.

7.1c Reduce homicides among black men aged 15 through 34 to no more than 72.4 per 100,000 black men. (Baseline: 90.5 per 100,000 in 1987)

7.1e Reduce homicides among black women aged 15 through 34 to no more than 16.0 per 100,000 black women. (Baseline: 20.0 per 100,000 in 1987)

8.1a* Increase years of healthy life among blacks to at least 60 years. (Baseline: An estimated 56 years in 1980)

Note: Years of healthy life (also referred to as quality-adjusted life years) is a summary measure of health that combines mortality (quantity of life) and morbidity and disability (quality of life) into a single measure. For people aged 65 and older, active life-expectancy, a related summary measure, also will be tracked.

8.11 Increase to at least 50 percent the proportion of counties that have established culturally and linguistically appropriate community health promotion programs for racial and ethnic minority populations. (Baseline data available in 1992)

Note: This objective will be tracked in counties in which a racial or ethnic group constitutes more than 10 percent of the population.

Healthy People 2000
Objectives Targeting Blacks
(continued)

9.1b Reduce deaths among black males caused by unintentional injuries to no more than 51.9 per 100,000 black males. (Age-adjusted baseline: 64.9 per 100,000 in 1987)

9.4c Reduce deaths among black men aged 30 through 69 from falls and fall-related injuries to no more than 5.6 per 100,000 black men. (Baseline: 8 per 100,000 in 1987)

9.5c Reduce drowning deaths among black males to no more than 3.6 per 100,000 black males. (Age-adjusted baseline: 6.6 per 100,000 in 1987)

9.6c Reduce residential fire deaths among black males to no more than 4.3 per 100,000 black males. (Age-adjusted baseline: 5.7 per 100,000 in 1987)

9.6d Reduce residential fire deaths among black females to no more than 2.6 per 100,000 black females. (Age-adjusted baseline: 3.4 per 100,000 in 1987)

11.1a Reduce asthma morbidity among blacks, as measured by a reduction in asthma hospitalizations to no more than 265 per 100,000 blacks. (Baseline: 334 per 100,000 blacks and other non-whites in 1987)

11.4a Reduce the prevalence of blood lead levels exceeding 15 µg/dL and 25 µg/dL among inner-city low-income black children (annual family income less than $6,000 in 1984 dollars) to no more than 75,000 and zero, respectively. (Baseline: An estimated 234,900 had levels exceeding 15 µg/dL, and 36,700 had levels exceeding 25 µg/dL, in 1984)

13.1c Reduce dental caries (cavities) so that the proportion of black children aged 6 through 8 with one or more caries (in permanent or primary teeth) is no more than 40 percent. (Baseline: 61 percent in 1986-87)

13.2c Reduce untreated dental caries so that the proportion of black children with untreated caries (in permanent or primary teeth) is no more than 25 percent among children aged 6 through 8 and no more than 20 percent among adolescents aged 15. (Baseline: 38 percent of black children aged 6 through 8 in 1986-87; 38 percent of black adolescents aged 15 in 1986-87)

14.1a Reduce the infant mortality rate among blacks to no more than 11 per 1,000 live births. (Baseline: 17.9 per 1,000 live births in 1987)

14.1e Reduce the neonatal mortality rate among blacks to no more than 7 per 1,000 live births. (Baseline: 11.7 per 1,000 live births in 1987)

14.1h Reduce the postneonatal mortality rate among blacks to no more than 4 per 1,000 live births. (Baseline: 6.1 per 1,000 live births in 1987)

Note: Infant mortality is deaths of infants under 1 year; neonatal mortality is deaths of infants under 28 days; and postneonatal mortality is deaths of infants aged 28 days up to 1 year.

14.2a Reduce the fetal death rate (20 or more weeks of gestation) among blacks to no more than 7.5 per 1,000 live births plus fetal deaths. (Baseline: 12.8 per 1,000 live births plus fetal deaths in 1987)

14.3a Reduce the maternal mortality rate among blacks to no more than 5 per 100,000 live births. (Baseline: 14.2 per 100,000 live births in 1987)

Note: The objective uses the maternal mortality rate as defined by the National Center for Health Statistics. However, if other sources of maternal mortality data are used, a 50-percent reduction in maternal mortality is the intended target.

14.4b Reduce the incidence of fetal alcohol syndrome among blacks to no more than 0.4 per 1,000 live births. (Baseline: 0.8 per 1,000 live births in 1987)

14.5a Reduce low birth weight among blacks to an incidence of no more than 9 percent of live births and very low birth weight to no more than 2 percent of live births. (Baseline: 12.7 and 2.7 percent, respectively, in 1987)

Note: Low birth weight is weight at birth of less than 2,500 grams; very low birth weight is weight at birth of less than 1,500 grams.

14.9b* Increase to at least 75 percent the proportion of black mothers who breastfeed their babies in the early postpartum period, and to at least 50 percent the proportion who continue breastfeeding until their babies are 5 to 6 months old. (Baseline: 25 percent at discharge from birth site and 8 percent at 5 to 6 months in 1988)

Healthy People 2000
Objectives Targeting Blacks
(continued)

14.11a Increase to at least 90 percent the proportion of pregnant black women who receive prenatal care in the first trimester of pregnancy. (Baseline: 61.1 percent of live births in 1987)

15.1a* Reduce coronary heart disease deaths among blacks to no more than 115 per 100,000 blacks. (Age-adjusted baseline: 163 per 100,000 in 1987)

15.2a Reduce stroke deaths among blacks to no more than 27 per 100,000 blacks. (Age-adjusted baseline: 51.2 per 100,000 in 1987)

15.3a Reverse the increase in end-stage renal disease (requiring maintenance dialysis or transplantation) among blacks to attain an incidence of no more than 30 per 100,000 blacks. (Baseline: 32.4 per 100,000 in 1987)

15.5b Increase to at least 80 percent the proportion of black hypertensive men aged 18 through 34 who are taking action to help control their blood pressure. (Baseline: 63 percent of aware black hypertensive men aged 18 through 34 were taking action to control their blood pressure in 1985)

Note: High blood pressure is defined as blood pressure equal to or greater than 140 mm Hg systolic and/or 90 mm Hg diastolic and/or taking antihypertensive medication. Actions to control blood pressure include taking medication, dieting to lose weight, cutting down on salt, and exercising.

16.11e Increase to at least 80 percent the proportion of black women aged 40 and older who have ever received a clinical breast examination and a mammogram, and to at least 60 percent those aged 50 and older who have received them within the preceding 1 to 2 years. (Baseline: 28 percent of black women aged 40 and older "ever" in 1987; 19 percent of black women aged 50 and older "within the preceding 2 years" in 1987)

17.2c Reduce to no more than 9 percent the proportion of blacks who experience a limitation in major activity due to chronic conditions. (Baseline: 11.2 percent in 1988)

Note: Major activity refers to the usual activity for one's age-gender group whether it is working, keeping house, going to school, or living independently. Chronic conditions are defined as conditions that either (1) were first noticed 3 or more months ago, or (2) belong to a group of conditions such as heart disease and diabetes, which are considered chronic regardless of when they began.

17.9a Reduce diabetes-related deaths among blacks to no more than 58 per 100,000 blacks. (Age-adjusted baseline: 65 per 100,000 in 1986)

17.10a Reduce end-stage renal disease due to diabetes among blacks with diabetes to no more than 2 per 1,000 blacks with diabetes. (Baseline: 2.2 per 1,000 in 1983-86)

17.10c Reduce lower extremity amputations due to diabetes among blacks with diabetes to no more than 6.1 per 1,000 blacks with diabetes. (Baseline: 10.2 per 1,000 in 1984-87)

Note: End-stage renal disease (ESRD) is defined as requiring maintenance dialysis or transplantation and is limited to ESRD due to diabetes. Blindness refers to blindness due to diabetic eye disease.

17.11e Reduce diabetes among blacks to a prevalence of no more than 32 per 1,000 blacks. (Baseline: 36 per 1,000 in 1987)

18.1b Confine annual incidence of diagnosed AIDS cases among blacks to no more than 37,000 cases. (Baseline: An estimated 14,000-15,000 cases diagnosed in 1989)

Note: Targets for this objective are equal to upper bound estimates of the incidence of diagnosed AIDS cases projected for 1993.

19.1a Reduce gonorrhea among blacks to an incidence of no more than 1,300 cases per 100,000 blacks. (Baseline: 1,990 per 100,000 in 1989)

19.3a Reduce primary and secondary syphilis among blacks to an incidence of no more 65 cases per 100,000 blacks. (Baseline: 118 per 100,000 in 1989)

Healthy People 2000
Objectives Targeting Blacks
(continued)

20.4b Reduce tuberculosis among blacks to an incidence of no more than 10 cases per 100,000 blacks. (Baseline: 28.3 per 100,000 in 1988)

21.2h Increase to at least 50 percent the proportion of blacks who have received, as a minimum within the appropriate interval, all of the screening and immunization services and at least one of the counseling services appropriate for their age and gender as recommended by the U.S. Preventive Services Task Force. (Baseline data available in 1991)

21.3b Increase to at least 95 percent the proportion of blacks who have a specific source of ongoing primary care for coordination of their preventive and episodic health care. (Baseline: Less than 80 percent in 1986, as 20 percent reported having no physician, clinic, or hospital as a regular source of care)

21.8 Increase the proportion of all degrees in the health professions and allied and associated health profession fields awarded to members of underrepresented racial and ethnic minority groups as follows:

	1985-1986 Baseline	*2000 Target*
Blacks	5%	8%

Note: Underrepresented minorities are those groups consistently below parity in most health profession schools—blacks, Hisponics, and American Indians and Aloska Natives.

22.4 Develop and implement a national process to identify significant gaps in the Nation's disease prevention and health promotion data, including data for racial and ethnic minorities, people with low incomes, and people with disabilities, and establish mechanisms to meet these needs. (Baseline: No such process exists in 1990)

Note: Disease prevention and health promotion data includes disease status, risk factors, and services receipt data. Public health problems include such issue areas as HIV infection, domestic violence, mental health, environmental health, occupational health, and disabling conditions.

APPENDIX 3

Healthy People 2000
Objectives Targeting American Indians and Alaska Natives

2.3d* Reduce overweight to a prevalence of no more than 30 percent among American Indians and Alaska Natives. (Baseline: An estimated 29-75 percent for different tribes in 1984-88)

Note: For people aged 20 and older, overweight is defined as body mass index (BMI) equal to or greater than 27.8 for men and 27.3 for women. For adolescents, overweight is defined as BMI equal to or greater than 23.0 for males aged 12 through 14, 24.3 for males aged 15 through 17, 25.8 for males aged 18 through 19, 23.4 for females aged 12 through 14, 24.8 for females aged 15 through 17, and 25.7 for females aged 18 through 19. The values for adolescents are the age- and gender-specific 85th percentile values of the 1976-80 National Health and Nutrition Examination Survey (NHANES II), corrected for sample variation. BMI is calculated by dividing weight in kilograms by the square of height in meters. The cut points used to define overweight approximate the 120 percent of desirable body weight definition used in the 1990 objectives.

2.10d Reduce the prevalence of anemia to less than 10 percent among Alaska native children aged 1 through 5. (Baseline: 22-28 percent in 1983-85)

Note: Iron deficiency is defined as having abnormal results for 2 or more of the following tests: mean corpuscular volume, erythrocyte protoporphyrin, and transferrin saturation. Anemia is used as an index of iron deficiency. Anemia among Alaska Native children was defined as hemoglobin <11 gm/dL or hemotocrit <34 percent. For pregnant women in the third trimester, anemia was defined according to CDC criteria. The above prevalences of iron deficiency and anemia may be due to inadequate dietary iron intakes or to inflammatory conditions and infections. For anemia, genetics may also be a factor.

3.4f* Reduce cigarette smoking to a prevalence of no more than 20 percent among American Indians and Alaska Natives. (Baseline: An estimated 42-70 percent for different tribes in 1979-87)

Note: A cigarette smoker is a person who has smoked at least 100 cigarettes and currently smokes cigarettes.

3.9a Reduce smokeless tobacco use by American Indian and Alaska Native youth to a prevalence of no more than 10 percent. (Baseline: 18-64 percent in 1987)

Note: For males aged 12 through 17, a smokeless tobacco user is someone who has used snuff or chewing tobacco in the preceding month. For males aged 18 through 24, a smokeless tobacco user is someone who has used either snuff or chewing tobacco at least 20 times and who currently uses snuff or chewing tobacco.

4.1a Reduce deaths among American Indian and Alaska Native men caused by alcohol-related motor vehicle crashes to no more than 44.8 per 100,000 American Indian and Alaska Native men. (Age-adjusted baseline: 52.2 per 100,000 in 1987)

4.2b Reduce cirrhosis deaths among American Indians and Alaska Natives to no more than 13 per 100,000 American Indians and Alaska Natives. (Age-adjusted baseline: 25.9 per 100,000 in 1987)

6.1d* Reduce suicides among American Indian and Alaska Native men in Reservation States to no more than 12.8 per 100,000 American Indian and Alaska Native men. (Age-adjusted baseline: 15 per 100,000 in 1987)

7.1f Reduce homicides among American Indians and Alaska Natives in Reservation States to no more than 11.3 per 100,000 American Indians and Alaska Natives. (Age-adjusted baseline: 14.1 per 100,000 in 1987)

8.11 Increase to at least 50 percent the proportion of counties that have established culturally and linguistically appropriate community health promotion programs for racial and ethnic minority populations. (Baseline data available in 1992)

Note: This objective will be tracked in counties in which a racial or ethnic group constitutes more than 10 percent of the population.

9.1a Reduce deaths among American Indians and Alaska Natives caused by unintentional injuries to no more than 66.1 per 100,000 American Indians and Alaska Natives. (Age-adjusted baseline: 82.6 per 100,000 in 1987)

9.3d Reduce deaths among American Indians and Alaska Natives caused by motor vehicle crashes to no more than 39.2 per 100,000 American Indians and Alaska Natives. (Age-adjusted baseline: 46.8 per 100,000 in 1987)

Healthy People 2000
Objectives Targeting American Indians and Alaska Natives
(continued)

13.1b Reduce dental caries (cavities) so that the proportion of American Indian and Alaska Native children aged 6 through 8 with one or more caries (in permanent or primary teeth) is no more than 45 percent. (Baseline: 92 percent in primary teeth and 52 percent in permanent teeth in 1983-84)

13.1d Reduce dental caries (cavities) so that the proportion of American Indian and Alaska Native adolescents aged 15 with one or more caries (in permanent or primary teeth) is no more than 70 percent. (Baseline: 93 percent in permanent teeth in 1983-84)

13.2b Reduce untreated dental caries so that the proportion of American Indian and Alaska Native children with untreated caries (in permanent or primary teeth) is no more than 35 percent among children aged 6 through 8 and no more than 40 percent among adolescents aged 15. (Baseline: 64 percent of American Indian and Alaska Native children aged 6 through 8 in 1983-84; 84 percent of American Indian and Alaska Native adolescents aged 15 in 1983-84)

13.5b Reduce the prevalence of gingivitis among American Indians and Alaska Natives aged 35 through 44 to no more than 50 percent. (Baseline: 95 percent in 1983-84)

13.11b* Increase to at least 65 percent the proportion of American Indian and Alaska Native parents and caregivers who use feeding practices that prevent baby bottle tooth decay. (Baseline data available in 1991)

14.1b Reduce the infant mortality rate among American Indians and Alaska Natives to no more than 8.5 per 1,000 live births. (Baseline: 12.5 per 1,000 live births in 1984)

14.1i Reduce the postneonatal mortality rate among American Indians and Alaska Natives to no more than 4 per 1,000 live births. (Baseline: 6.5 per 1,000 live births in 1984)

Note: Infant mortality is deaths of infants under 1 year; neonatal mortality is deaths of infants under 28 days; and postneonatal mortality is deaths of infants aged 28 days up to 1 year.

14.4a Reduce the incidence of fetal alcohol syndrome among American Indians and Alaska Natives to no more than 2 per 1,000 live births. (Baseline: 4 per 1,000 live births in 1987)

14.9d* Increase to at least 75 percent the proportion of American Indian and Alaska Native mothers who breastfeed their babies in the early postpartum period, and to at least 50 percent the proportion who continue breastfeeding until their babies are 5 to 6 months old. (Baseline: 47 percent at discharge from birth site and 28 percent at 5 to 6 months in 1988)

14.11b Increase to at least 90 percent the proportion of pregnant American Indian and Alaskan Native women who receive prenatal care in the first trimester of pregnancy. (Baseline: 60.2 percent of live births in 1987)

17.2b Reduce to no more than 11 percent the proportion of American Indians and Alaska Natives who experience a limitation in major activity due to chronic conditions. (Baseline: 13.4 percent in 1983-85)

Note: Major activity refers to the usual activity for one's age-gender group whether it is working, keeping house, going to school, or living independently. Chronic conditions are defined as conditions that either (1) were first noticed 3 or more months ago, or (2) belong to a group of conditions such as heart disease and diabetes, which are considered chronic regardless of when they began.

17.9b Reduce diabetes-related deaths among American Indians and Alaska Natives to no more than 48 per 100,000 American Indians and Alaska Natives. (Age-adjusted baseline: 54 per 100,000 in 1986)

Note: Diabetes-related deaths refer to deaths from diabetes as an underlying or contributing cause.

17.10b Reduce end-stage renal disease due to diabetes among American Indians and Alaska Natives with diabetes to no more than 1.9 per 1,000 American Indians and Alaska Natives with diabetes. (Baseline: 2.1 per 1,000 in 1983-86)

Note: End-stage renal disease (ESRD) is defined as requiring maintenance dialysis or transplantation and is limited to ESRD due to diabetes. Blindness refers to blindness due to diabetic eye disease.

17.11a Reduce diabetes among American Indians and Alaska Natives to a prevalence of no more than 62 per 1,000 American Indians and Alaska Natives. (Baseline: 69 per 1,000 aged 15 and older in 1987)

Healthy People 2000
Objectives Targeting American Indians and Alaska Natives
(continued)

20.3g* Reduce Hepatitis B (HBV) among Alaska Natives to no more than 1 case. (Baseline: An estimated 15 cases in 1987)

20.4d Reduce tuberculosis among American Indians and Alaska Natives to an incidence of no more than 5 cases per 100,000 American Indians and Alaska Natives. (Baseline: 18.1 per 100,000 in 1988)

20.7a Reduce bacterial meningitis among Alaska Natives to no more than 8 cases per 100,000 Alaska Natives. (Baseline: 33 per 100,000 in 1987)

21.2k Increase to at least 70 percent the proportion of American Indians and Alaska Natives who have received, as a minimum within the appropriate interval, all of the screening and immunization services and at least one of the counseling services appropriate for their age and gender as recommended by the U.S. Preventive Services Task Force. (Baseline data available in 1991)

21.8 Increase the proportion of all degrees in the health professions and allied and associated health profession fields awarded to members of underrepresented racial and ethnic minority groups as follows:

	1985-1986 Baseline	*2000 Target*
American Indians and Alaska Natives	0.3%	0.6%

Note: Underrepresented minorities are those groups consistently below parity in most health professian schools—blacks, Hispanics, and American Indians and Aloska Natives.

22.4 Develop and implement a national process to identify significant gaps in the Nation's disease prevention and health promotion data, including data for racial and ethnic minorities, people with low incomes, and people with disabilities, and establish mechanisms to meet these needs. (Baseline: No such process exists in 1990)

Note: Disease prevention and health promotion data includes disease status, risk factors, and services receipt data. Public health problems include such issue areas as HIV infection, domestic violence, mental health, environmental health, occupational health, and disabling conditions.

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